STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

AND

OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

CLAIMS PROCESSING
MARKET CONDUCT EXAMINATION
AND
LIMITED SCOPE FINANCIAL AND COMPLIANCE
EXAMINATION

OF

MEMPHIS MANAGED CARE CORPORATION
d/b/a TLC FAMILY CARE HEALTHPLAN

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2000 THROUGH MARCH 31, 2001

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DATE: October 21, 2002

SUBJECT: Claims Processing Market Conduct Examination and Limited Scope Financial and Compliance Examination

An on-site limited market conduct examination of claims processing and a limited scope financial examination of Memphis Managed Care Corporation, 1407 Union Avenue, Suite 1100, Memphis, Tennessee, 38104, was performed in July 2001. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination report "by test" of the claims processing system of Memphis Managed Care Corporation (MMCC). A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein. Further, this report reflects the results of a limited scope review of financial statement account balances as reported by MMCC.

II. PURPOSE AND SCOPE

A. Authority

This examination of MMCC was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6.of the TennCare contract between the State of Tennessee and MMCC, Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

MMCC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of MMCC. Sixty claims were selected for testing from paid and denied claims processed by MMCC during April 2001. The fieldwork was performed in July 2001.

The limited scope financial examination and compliance focused on the balance sheet and income statement as reported by MMCC on its National Association of Insurance Commissioners (NAIC) Quarterly Statement for the period ended March 31, 2001 and MMCC's compliance with Title VI.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that MMCC's operations were administered in accordance with the TennCare Contract as well as state statutes and regulations concerning HMO operations, thus reasonably assuring

that the MMCC TennCare members receive uninterrupted delivery of health care services on an on-going basis.

The objectives of the examination were to:

- Determine whether MMCC met its contractual obligations under its Contractor Risk Agreement with the State (the "TennCare contract") and whether MMCC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 et seq.;

- Determine whether MMCC had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether MMCC properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether MMCC had corrected deficiencies outlined in prior reviews of MMCC conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Brief Overview

Memphis Managed Care Corporation was organized as a nonprofit organization by its members, The Regional Medical Center at Memphis, and UT Medical Group, Inc. MMCC was incorporated on July 7, 1993 and was licensed as an HMO with the state on November 24, 1993. Effective January 1, 1994, MMCC contracted with the State of Tennessee as a health maintenance organization to provide medical services under the newly established TennCare Program. The Memphis Managed Care Corporation's designated name for the TennCare plan is TLC Family Care Healthplan.

During the period under examination, MMCC was licensed by TDCI to operate in the community service areas (CSAs) of Shelby County, Northwest Tennessee, and Southwest Tennessee. MMCC derives all of its revenue in the form of capitation payments from the state for providing medical benefits to TennCare members. As of March 31, 2001, MMCC had approximately 86,000 TennCare members. Since the end of the audit period, MMCC has expanded its enrollment. As of August 30, 2001, MMCC had approximately 163,000 enrollees.

B. Claims Processing Not Performed by MCO

During the examination period, MMCC subcontracted with the following vendor for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- MIM Health Plans, Inc., as its pharmacy benefits manager.

Because the subcontractor processed the claims for these benefits, claims for these types of services were not included in MMCC's pool of claims from which claims were selected for detailed testing. Therefore, no pharmacy claims were tested for compliance with section 2-18. of the TennCare contract and Tenn. Code Ann. § 56-32-226(b) (the "Prompt Pay Act").

IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period January 1, 1998, through March 31, 1999, released July 7, 1999. Also at this time, the state retained Peterson Worldwide, LLC, ("Peterson") a consulting group, to review MMCC's financial operations and denied and pended claims.

Discrepancies in Claims Processing.

The following deficiencies were determined to exist in the sample of claims reviewed by Peterson and TDCI:

1. MMCC did not process claims in the sample in accordance with Section 2-18. of the TennCare contract. Ten percent of clean claims in the sample were processed within 30 days, 14% of clean claims were processed within 40 days, and 34% of all claims in the sample were processed within 60 days.

2. Three claims were paid with incorrect amounts because of non-system, manual errors.

3. Copayment accumulation is not performed by the Diamond Claims System and, therefore, it could not be readily determined whether out-of-pocket payments were within maximum annual out-of-pocket liability limitations.

4. Peterson reviewed a sample of 50 claims and determined that 2 claims were inappropriately denied.

5. A current aged pended claims report as of April 29, 1999, indicated 49% of the aged pended claims were 61 days or older (per Peterson's report).

6. Explanation of benefits (EOBs) statements are not currently being provided to uninsured and uninsurable enrollees.

7. Of the 46 hard copy claims requested, 1 claim was not received and 6 of the hard copy claims reviewed contained data elements that did not match the system claims data.

8. MMCC did not report reliable claims aging data on its weekly claims processing reports submitted to the state. While the examiners were on site, MMCC corrected the reports that calculate the aging of processed claims.

9. Claims are not electronically controlled until they are actually adjudicated.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Claims Processing Market Conduct Examination

The following deficiencies were determined to exist during the claims processing market conduct examination of MMCC for the month of April 2001:

1. MMCC did not process claims in accordance with the prompt pay requirements.

2. Two of the 60 claims examined had procedure codes entered incorrectly.

3. One of the 60 claims examined was denied using the incorrect denial code.

4. One of the 60 claims did not have all the lines from the claim entered into the claims processing system. This omission did not result in a mispayment of the claim.

5. One claim did not pay in accordance with the negotiated rate with the provider.

6. Of the 5 claims examined with copayment responsibilities, the benefit accumulator for 3 claims failed to include all applicable copayments.

B. Summary of Deficiencies – Limited Scope Financial Examination

MMCC failed to correctly apply the $50,000 investment threshold per T.C.A. Section 56-3-307 for investments including electronic computer or data processing machines or systems having an original cost of at least $50,000. In addition, MMCC failed to apply Statement of Statutory Accounting Principle Number 16 which limits the aggregate amount of admitted EDP equipment and operating system software (net of accumulated depreciation) to three percent of the reporting entity's capital and surplus as shown on the statutory balance sheet of the reporting entity for its most recently filed statement, adjusted to exclude any EDP equipment and operating system software, net deferred tax assets and net positive good will. MMCC's net worth includes $669,813 of EDP equipment and operating software that should be non-admitted. Net worth will be decreased by $669,813.

C. Summary of Deficiencies – Other Findings and Analyses-Claims Processing

The weekly claims processing report failed to report subcontractor claim data.

VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING SYSTEM

A. Claims Selected For Testing

MMCC provided a data file of paid and denied claims for the month of April 2001. Per the data file submitted by MMCC for claims adjudicated in April 2001, $9,228,922.52 was paid which agrees to the paid claims triangle submitted for the month of April 2001.

For each claim processed, the data file included the amount paid and, if applicable, an explanation of the reason for denial. From the data file, 60 claims were judgmentally selected for testing as follows:

- Fifty claims with at least one line denied were selected with at least one from each claim type and one for each unique denial code.

- Ten claims were selected at random from the paid claims.

B. Julian Date Testing

A Julian date is stamped on each incoming claim to indicate the date the claim was received. Julian dates were tested to ensure that claims were being aged accurately

for timeliness reporting. Sixteen (16) claims were randomly selected from a batch of incoming mail on July 10, 2001. Screenprints of the claims after being entered into the system were requested; fourteen were received. These 14 screenprints had a received date of July 10, 2001. The other 2 claims were not in the claims processing system due to "no mbr listed" and "mbr not eligible."

C. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in the prompt pay requirements of TCA § 56-32-226(b) which requires that 90% of clean claims be processed within 30 days and 99.5% of all claims be processed within 60 days.

On January 25, 2001 and April 12, 2001 the TDCI requested a data file from all MCOs containing **all** claims processed during the months of January 2001 and April 2001 respectively. Due to MMCC's non-compliance with the prompt pay requirements in April 2001, additional files were requested for the months of May 2001, June 2001, and July 2001. The data file was used to determine each MCO's compliance with the processing requirements defined in TCA § 56-32-226(b) and Section 2-18 of the TennCare Contract. Because these tests were performed on all claims processed within the month, no projections to the population were needed.

MMCC was in compliance with the prompt pay requirements in the month of January 2001 and July 2001; however, MMCC failed to comply with the prompt pay requirements in the months of April 2001, May 2001, and June 2001.

The January 2001, April 2001, May 2001, June 2001, and July 2001, claims processing timeliness results of the data submitted by MMCC compared to the requirements of TCA 56-32-226(b)(1) are as follows:

	Within 30 days	Within 60 days	Greater than 60 days
January 2001	97.10%	99.70%	.3%
April 2001	82.66%	99.19%	.81%
May 2001	80.99%	99.30%	.70%
June 2001	87.37%	98.93%	1.07%
July 2001	94.39%	99.58%	.42%
T.C.A. Requirement	90%	99.5%	.5%

Management's Response: Management concurs. It is agreed that during the months tested, MMCC did not comply with the prompt payment requirements, however for the 12 month period following this report MMCC has met full compliance.

Rebuttal: MMCC was not in compliance with prompt pay requirements in January 2002. MMCC submitted claims data for February 2002, and TDCI determined that MMCC was in compliance in February 2002.

D. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. Results of the adjudication testing are as follows:

1. Two claims (0000000003069800 and 0000000008296260) had procedure codes entered incorrectly.

   Management's Response: Management does not concur with findings on claim #3069800. The claim was an electronic submission by the provider with an incorrect deleted non-valid code. The claim was corrected with the valid applicable code once received for processing. The second claim mentioned was not a timely submission by the provider and was not eligible for consideration of payment so any coding error is incidental. The handling of both of the above instances did not result in a mispayment of either claim.

   Rebuttal: The original procedure code submitted by the provider was not entered into the claims processing system.

2. One claim (0000000008363490) used inappropriate denial codes. The claim denied as "type of bill invalid or missing" when the denial code should have been duplicate claim.

   Management's Response: Management concurs that the incorrect denial code was used, however this did not result in a mispayment of the claim.

3. One claim (0000000008286230) did not have a line from the claim keyed into the claims processing system. This did not result in mispayment of the claim.

   Management's Response: Management concurs.

E. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments allowed for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts were calculated correctly.

Of 14 paid claims tested, 13 were priced accurately according to the executed provider contracts. One claim was incorrectly priced (0000001032001781).

Management's response: Management concurs. Policies and Procedures have been drafted and approved by the health plan to be used in the ongoing training of adjudicators, pricing and contract specialists on issues concerning pricing and system set-ups for accuracy. In addition, a system upgrade is underway to automate adjudication and pricing of contracts and claims.

F. Withhold, Deductible and Coinsurance Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. MMCC does not withhold a certain percentage of payments from providers.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments on certain procedures, whether out-of-pocket payments are within liability limitations, and whether out-of-pocket payments are accurately calculated in accordance with Section 2-3.k. of the TennCare contract.

   Effective January 1, 1998, MMCC waived all deductibles. Five claims in the sample were subject to copayments. All copayments were correctly applied and calculated. The claims system, however, did not properly accumulate copayments. Manually adjudicated or adjusted claim lines cannot be accessed by the claims processing system's benefit accumulator. This could result in an enrollee exceeding the out-of-pocket maximum. Of the 5 enrollees tested, the benefit accumulator for 3 enrollees (0000000008435300; 0000000008664040; and 0000001081000016) failed to include all applicable copayments due to manual adjustments. This deficiency was noted in the prior examination report dated March 31, 1999.

   Management's Response: Management concurs. MMCC is presently undergoing a claims system upgrade. All systems medical definitions, benefit rules and benefit packages has or will be re-constructed. We agree that the system did not in all cases handle this situation correctly. MMCC fully anticipates that this deficiency will be corrected in the new system upgrade slated for implementation in November 2002.

G. Pended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been pended by MMCC, the principal reasons for the pended claims, the number of pended claims that are over 60 days old, and whether a potential material unrecorded liability exists because of pended claims. MMCC provided the examiners with a pended claims report that included each claim type (HCFA1500 and UB92) as of July 19, 2001. A total of 4,442 pended claims was reported, including 409 claims which were unprocessed for more than 60 days. This is 9.2% of the total pended claims. The oldest claim on the pend report was received June 12, 1999. The next oldest claim was from February 27, 2000.

H. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices. MMCC provides EOBs to enrollees whose claims are subject to cost sharing.

I. Remittance Advice Testing

The purpose of testing remittance advices is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. MMCC provided the examiners with 10 remittance advices. No discrepancies were noted in the review of the these remittance advices.

J. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the payment of claims by MMCC; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested 4 checks for testing. All 4 checks cleared through the bank account within a reasonable time after the issue date.

K. Comparison of Actual Claim with System Claim Data

The purpose of comparing the data on the hard copy claims to the data entered into the claims system is to ensure that the claims data received by MMCC is accurately entered into the claims system. Data must be entered accurately to ensure that claims

are adjudicated appropriately and that encounter data is reported correctly to the TennCare Bureau.

The examiners requested the 60 original claims selected for testing. The data elements from the claims provided were compared to the data elements entered into MMCC's claims processing system. The following deficiencies were noted:

- Two claims (0000000003069800 and 0000000008296260) had procedure codes entered incorrectly.

  Management's Response: Management does not concur with findings on claim #3069800. The claim was an electronic submission by the provider with an incorrect deleted non-valid code. The claim was corrected with the valid applicable code once received for process. The second claim mentioned was not a timely submission by the provider and was not eligible for consideration of payment so any coding error is incidental. The handling of both of the above instances did not result in a mispayment of either claim.

  Rebuttal: The original procedure code submitted to MMCC by the provider was not entered into the claims processing system.

- One claim (0000000008286230) did not have a line from the claim keyed into the claims processing system. This omission did not result in a mispayment of the claim.

  Management's Response: Management concurs.

L. Electronic Claims Capability

Section 2-18 of the TennCare contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment [. . .]." Section 2-2.g. of the TennCare contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. MMCC has the ability to receive both physician HCFA-1500 and hospital-UB 92 claims electronically and is therefore in compliance with the contract.

VII. REPORT OF OTHER FINDINGS AND ANALYSES - CLAIMS PROCESSING

A. Weekly Claims Processing Reports

The July 27, 2001 weekly claims processing report was selected for review and MMCC was requested to provide supporting documentation for this report. The following deficiency was noted in the weekly claims processing report:

- MMCC failed to report subcontractor claim data.

Management's Response: Management does not concur. MMCC has no subcontractor data to report. MIM which is the pharmacy benefits manager for TLC is the only sub-contractor that may fall within this category and have not historically supplied this information. Effective with the newly amended and restated Contractor Risk Agreement, MIM will now provide this information to MMCC who in turn will furnish to the Bureau of TennCare on a weekly basis.

Rebuttal: Section 2.11.g. of the Contractor Risk Agreement requires MCOs to provide weekly activity reports including claims processing status reports. This weekly report should include the number of unpaid claims in inventory by service type.

B. Provider Manual

The provider manual outlines written guidelines to the provider to assure that the claims are processed accurately and timely. In addition, the provider manual informs the providers of the correct procedures to follow in the event of a disputed claim. A review of MMCC's Provider Manual revealed no weaknesses.

VIII. REPORT OF FINDINGS AND ANALYSES – FINANCIAL REVIEW

A. Financial Overview

MMCC files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the managed care organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity.

Additionally, T.C.A. § 56-32-212(5) defines the term "admitted assets" for the purposes of calculating a health maintenance organization's net worth.

MMCC's NAIC Statement for the quarter ended March 31, 2001, reported $27,135,114 in admitted assets, $18,587,042 in liabilities and $8,548,073 net worth. MMCC reported total revenues of $38,868,909, and total expenses of $36,445,244, resulting in a net gain of $2,423,665 for the period January 1 through March 31, 2001. Revenue consists of $38,423,772 in capitation payments from the TennCare Program, $415,037 in investment income, and $30,100 in other revenue. The plan reported $33,162,798 in medical and hospital expenses and $3,282,446 in administrative expenses. Premium taxes paid to the State were reported as $768,475. Medical and hospital expenses represent 86.3% of capitation payments from TennCare, and administrative expenses less premium taxes represent 6.5% of capitation fee payments from TennCare.

The results of the financial tests performed revealed a discrepancy in MMCC's preparation of the NAIC Statement for the quarter ended March 31, 2001 (see Results of Financial Tests Performed). As a result of examination testwork, examiners adjusted MMCC's net worth as of March 31, 2001 from $8,548,073 to $7,848,260 resulting in a statutory net worth excess of $2,533,714 (see Schedule of Examination Adjustments to Net Worth).

B. Financial Tests Performed

TDCI reviewed the account balances on the NAIC Statement for the quarter ended March 31, 2001 to determine if balance sheet and income statement amounts were properly reported as required by NAIC guidelines and Tennessee Code Annotated. This review included the following tests:

- The trial balance for the quarter ended March 31, 2001 was reconciled to NAIC Statement for the quarter ended March 31, 2001.
- Cash and cash equivalents balances were verified through bank statements and bank reconciliations.
- Investment balances were confirmed against investment statements.
- Receivables were reviewed for admittance purposes under NAIC guidelines.
- Claims payable was reviewed for adequacy. This was accomplished by determining total medical payments subsequent to the period for dates of service during the reporting period.

- Other payables were reviewed for accuracy.

- Premium revenue was verified through documentation of payments from the TennCare Bureau.

- Other revenues were reviewed for accuracy.

- Medical expenses were reviewed for accuracy through testing of payments by the claims processing system and capitation payments to providers. Effective July 1, 2000, the TennCare contract required MMCC to pay medical providers at least 85% of the TennCare capitation payments for the provision of medical services. Additional tests were performed to ensure that medical expenses were recorded in the proper period for the 85% provision.

- Administrative expenses were reviewed for accuracy.

- Events subsequent to the reporting period were reviewed for their effect on account balances as of March 31, 2001.

C. Results of Financial Test Work Performed

1. Claims Payable and Provider Contingent Liabilities

   TDCI reviewed payments by the claims processing system for dates of service through March 31, 2001. MMCC's claims unpaid at March 31, 2001 appear to be adequate. During April and May 2001, MMCC paid a total of $16,854,893 of claims in which $13,039,252 were for claims with dates of service March 2001, and prior, thereby completing 78.4% of the claims payable estimate at March 31, 2001.

2. Medical Loss Ratio Reports

   Effective July 1, 2000, Section 3-10.c.1 of the TennCare contract required all TennCare MCOs "to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a fiscal year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed [. . .]. The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees."

Examiners tested the medical loss ratio reports to ensure medical expenses were allowable under the definition of medical expenses as defined in Section 1-3 of the TennCare Contract. These tests included ensuring that administrative costs of subcontractors were excluded from the calculation of the medical loss ratio. Medical expenses were verified by testing payments by the claims processing systems for dates of service after July 1, 2000 through May 31, 2001.

3. Cash and Investments

   As of March 31, 2001, MMCC reported cash as an admitted asset of $23,396,230, zero admitted assets for short-term investments, and $1,822,184 in admitted assets for long term investments.

4. Restricted Deposit

   During the examination period, MMCC was required to maintain a restricted deposit with a maturity value of $1,900,000 at March 31, 2001, to satisfy requirements of T.C.A. § 56-32-212(b)(3). MMCC had pledged to the Commissioner of TDCI a total of $2,015,000 par value securities and TDCI held the safekeeping receipts for these securities.

5. Health Care Receivable, Premium Receivable and TennCare Premium Revenue

   MMCC reported health care receivable of $634,915, and premium receivables of zero as of March 31, 2001. For the period January 1, through March 31, 2001 MMCC reported TennCare premium revenue of $38,423,772.

   The $634,915 represents the 5% withhold from the TennCare Capitation Premium for the month of March 2001. This should have been reported on line 10 of the NAIC asset schedule as Accident and Health Premiums Due and Unpaid.

   Premium revenue through March 31, 2001 of $38,423,772 was correctly reported.

6. Electronic Data Processing Equipment And Software

   MMCC failed to correctly apply the $50,000 investment threshold per T.C.A. Section 56-3-307 for investments including electronic computer or data processing machines or systems having an original cost of at least $50,000. MMCC admitted a total of $899,277 electronic data processing equipment and

software on the NAIC statement; however, the maximum amount per MMCC's asset listing totals $726,498.

MMCC failed to apply Statement of Statutory Accounting Principle Number 16. SSAP No.16 limits the aggregate amount of admitted EDP equipment and operating system software (net of accumulated depreciation) to three percent of the reporting entity's capital and surplus as shown on the statutory balance sheet of the reporting entity for its most recently filed statement, adjusted to exclude any EDP equipment and operating system software, net deferred tax assets and net positive goodwill. MMCC's net worth includes $669,813 of EDP equipment and operating software that should be non-admitted.

Net worth will be decreased by $669,813.

7. Working Capital

MMCC must establish and maintain a positive working capital defined as current assets greater than current liabilities per T.C.A. § 56-32-212(a)(6). MMCC's current assets exceed current liabilities at March 31, 2001.

D. Schedule of Examination Adjustments to Net Worth

Statutory net worth as reported on NAIC Statement for the quarter ended March 31, 2001	$8,548,073
Less: Non admittable EDP equipment and software	($699,813)
Adjusted net worth based on examination adjustments	$7,848,260
Statutory net worth requirement as of March 31, 2001	$5,314,546
Statutory Net Worth Excess as of March 31, 2001	**$2,533,714**

Management's Response: MMCC concurs with the adjustments made to net worth resulting in a statutory net worth excess of $2,533,714.

IX. TITLE VI

Effective July 1996, Section 2-25 of the TennCare Contract required MMCC to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various MMCC staff and a review of policies and related supporting documentation, MMCC was found to be in compliance with Section 2-25 of the TennCare Contract.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of MMCC.